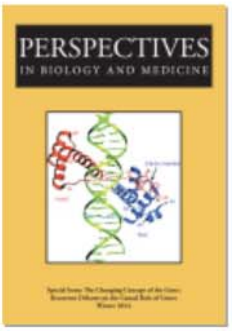
Misconceiving Medical Leadership

Malcolm Parker



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ABSTRACT Medical leadership and leadership education have recently emerged as subjects of an expanding though as yet uncritical literature. Considerable attention is being given to the development of courses and electives, together with some proposals for generalizing these offerings to all medical students and doctors. This article briefly sketches this development and its derivation from business and corporate leadership models and accompanying literature, and subjects its adoption by medicine to critical scrutiny. Putative motivations for these developments are discussed, and an alternative explanation is offered, tied to the loss of physician status. The nature of leadership as complex, emergent, and unpredictable has been ignored in the promotion of medical leadership and leadership training, and this is reflected in the false assumption that leadership in medicine is something that can be taught. Although the leadership literature is beginning to recognize these complex aspects of leadership, so far their implications have not been acknowledged. This article aims to stimulate further analytic discussion of this under-theorized aspect of medicine.

In December 2010, the Queensland rural town of Theodore was flooded by the Dawson River and Castle Creek, necessitating the total evacuation of its citizens and destroying the private practice of the town's general medical practitioner of 30 years, Bruce Chater (Theodore Medical Centre 2012). Chater was responsible for the continuing management of patients during the crisis, but he also co-led the evacuation and initial rebuilding of the town and was instrumental in maintaining the citizens' determination not to let the disaster break their spirit. In the aftermath, Chater stated that the best thing about working in rural towns was the partnerships: "Between you and the community. Between

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you and the patients. It's that ability to work with people about their condition to understand them and hopefully make a difference" (Kemp 2012). Chater was recognized by the Australian College of Rural and Remote Medicine and the Rural Doctors Association of Australia, with an award for his long-term dedication to the Theodore community, his work during the floods, and his advocacy for generalist rural medicine at the state, national, and international levels.

Chater is clearly a leader among leaders of the Australian rural medical community, and an inspirational leader within the medical profession in Australia more generally. Yet he received no formal leadership training during his undergraduate or postgraduate education, something now being advocated as an important element of medical education at all levels. A question that arises in response to the recent phenomenon of medical leadership and leadership education is why this apparent need has emerged, given that there have always been recognized leaders within the medical profession—as in other professions and, indeed, all walks of life.

This article attempts to answer that question. The first part includes an account of the perceived need for medical leadership and leadership education, descriptions of different leadership models from the general and the medical literatures, and an update on current medical leadership aspirations, education, and training. The second part critiques medical leadership and leadership education from a number of perspectives. From this critique I derive two central assertions. First, leadership is not teachable: it occupies a different category from the various competencies that students and doctors must master and, at least initially, be taught. Second, the rise of the medical leadership movement is more of a reaction to the loss of physician status than a justified response to an identified need.

MOTIVATIONS: THE NEED FOR LEADERSHIP AND LEADERSHIP EDUCATION

Crises call for leaders. For example, while frequently described as a mediocre peacetime prime minister, Churchill is generally regarded as having emerged in response to German aggression as the wartime leader par excellence. In the current era of crises—financial, terrorist, climate change, humanitarian—medicine and health care are not immune. Some commentators take the "health care crisis" as so self-evident that they do not bother to describe its elements or justify the attribution (Crites, Ebert, and Schuster 2008), although the lack of universal insurance coverage, inadequate access to care, social inequities in health status, and insatiable demands fuelled by technological advancements and the ageing population are often cited (Goldstein et al. 2009). Such a multifaceted crisis calls for leadership, or so it is claimed, and the medical profession is seen as a natural repository of potential leaders to help us deal with its threats and challenges. And whether there is a genuine crisis, or just the promotion of the per-

ception of one, it is not surprising that medical educators are being urged to turn their attention to producing the medical leaders of the future.

Of course, current calls for medical leadership do not mean that medicine has not produced leaders throughout its history; that medical leadership is not new will be one of the themes of this article, particularly in relation to the call for medical education to become involved in training leaders. In recent times, leaders have emerged in developments such as evidence-based medicine, the greater acknowledgment of medical error, and the consequent patient safety agenda (Cohen 1996; Leape 2002; Sackett et. al. 1996; Small and Barach 2002). Patient safety is now included in many undergraduate medical programs, and different ways of encouraging student leadership of this curricular element are emerging, such as via interprofessional learning (Hoffman et. al. 2008; Holmes, Balas, and Boren 2002; Nie et. al. 2011). Current calls for leadership in medicine represent, in part, a sensitivity response to criticism leveled at the profession for its failures to heed the lessons from other industries—for example, in safety processes—and to initiate developments in this and other areas.

Whether or not there is a health-care crisis, the delivery of health care is often said to have become significantly more complex through the development of institutions and systems of care, over and above the traditional dyadic clinical relationship. Such systems are considered important for coordination and standardization of care and are now governed by targets, regulations, quality agendas, and resource restrictions, among other factors that until recently have been more familiar to the corporate world than to medicine (Swanwick and Mc Kimm 2011). Disease prevention, health promotion, and population health strategies are predicted to become more prominent, and these also require systematic management rather than an individual treatment focus (McKimm and Swanwick 2011). Health-care delivery through the complex networks of organizational performance is seen as requiring leadership to a greater extent than the simpler clinical relationships of yesteryear.

As health systems become more technology-based and corporate/managerial in nature, the traditional characteristics and competencies of physicians, and the training required to instill them, are also coming to be seen as less relevant than they were in simpler times (Stoller 2009). To some extent, medical students now learn collaboratively in teams, and physicians must work in the same way, rather than as individual, independent clinicians who were traditionally tested and evaluated as such (Chen et. al. 2009). As members of health organizations, they must also learn to think in additional, different ways to the clinical and the pathophysiological (Stoller 2004). Clinical skills do not translate directly into the capacities required of system players, managers, and leaders; there is evidence of the need for increased exposure to the managerial sciences in the organization and delivery of health care in complex settings (Larson, Chandler, and Forman 2003). In addition, there is said to be at least some emerging evidence that cer-

tain leadership styles may improve health outcomes (Carlson, Min, and Bridges 2009; Stoller 2009).

Higher education itself is a system subject to rapid change in recent times, and the need for leadership has been identified in relation to the speed of change, the need to ensure quality with diminishing resources (as with health-care delivery), larger student cohorts, and the exigencies of complex external environments that affect education (Hill and Stephens 2005).

Related to these changes are the developments in patient-centered care and the "democratization of health care processes and interactions," including the collaborative decision-making between physicians, other health professionals, and patients that lies at the heart of the patient-centered paradigm (Donetto 2012). The exercise of power in the clinic has been realigned in response to many factors that have been extensively explored through the literature of bioethics and patient-centered care, including abuses of clinical and related power and the phenomena of misdiagnosis, adverse events, patient harm, subsequent litigation, and the demise of pure models of self-regulation. Automatic trust of the medical profession in virtue of knowledge and social status is a thing of the past, and new models of professionalism have been advocated (Irvine 2007).

These are some of the factors that support current calls for more explicit and visible leadership within the medical profession. The apparent urgency of the need for greater and better leadership is, not surprisingly, accompanied by a call for educational changes that are relevant to new and more complex environments in health-system management and health-care delivery and are expected to prepare the medical leaders of these new institutions (O'Connell and Pascoe 2004).

TYPES OF MEDICAL LEADERSHIP

The developments sketched in the previous section are reflected in the new waves of research into leadership and leadership styles. Emerging typologies of leadership are identifiable, with a more-or-less agreed core, and this is being mapped to the purported requirements of medical leadership. Furthermore, the extent to which leadership is currently being described, analyzed, and categorized is interpreted to imply that leadership can be nurtured and taught.

As with patient safety, medicine is taking its lead in developing its own leadership agenda from other industries, from the corporate/management world, and from the academic analyses of leadership that have been enlisted there. Central to these analyses are the relations between power and leadership, and the consequent models of leadership are defined by how power is enlisted in achieving the goals of organizations and individual actors. These models are now being applied to the medical and health-care environments, not only in relation to complex systems and organizations, but also in relation to the physician-patient relationship. Related concepts and practices, such as physician advocacy for patients, may also be added to the mix (Earnest, Wong, and Federico 2010).

Gabel (2012) links power and leadership conceptually, defining *leadership* as "working in socially appropriate ways to influence others in subordinate or follower positions to achieve principle-driven goals and objectives that these individuals may not have wanted to reach, may not have thought of reaching, or may not have had the courage or motivation to attempt on their own," and *power* as involving "the strategies used by leaders to influence those in subordinate or follower positions to achieve these important goals" (p. 1153). These are clearly normative rather than purely factual conceptions of power and leadership, featuring as they do the fundamental element of influence that is necessary to any conception. Leaders influence their followers and subordinates, and doctors have certain powers in relation to patients, so we can discern here the beginnings of an idea that has been exploited in some of the medical leadership literature: that doctors are and should be leaders vis-à-vis their patients, as well as learning how to be leaders within organizations.

Various leadership styles have been identified and described. There are variations in their number and scope, but the central styles as established in the business management literature include autocratic, bureaucratic, charismatic, democratic/participative, transactional, and transformational (Johnson 2013; VectorStudy 2013). While all these styles may be encountered currently, there is also a historical dimension to leadership research and implementation. Thus, the first half of the 20th century has been identified as the "Great Man" period, with leadership emphasizing "characteristics such as charisma, intelligence, energy and dominance" (Swanwick and McKimm 2011, p. 24). However, these and other personality traits have not subsequently been shown to distinguish between leaders and non-leaders. According to Swanwick and McKimm, a subsequent wave of theory concerning leadership and decision-making styles was found inadequate to manage the rapid changes in corporate systems. These theories were superseded by the influential "transformational leadership" ideas of Bass and others (Bass 1990; Bass and Avolio 1994), who emphasized the facilitation by leaders of their followers' potential, consistent with explicit organizational goals and values (Hill and Stephens 2005; Swanwick and McKimm 2011).

Some authors see transformational leadership as itself having been eclipsed by newer models, such as "complex adaptive leadership" styles that are said to take account of the "complex interactions within dynamic systems" and of leaders as "catalysts for complex, emergent change within interactive networks, of which they form a part" (Hill and Stephens 2005, p. 145). However, the general transformational model has persisted in many organizations and training courses, including health organizations and health-care training institutions, based on the idea that different situations require different dynamic relationships and roles, and hence different people may emerge as leaders for different purposes, in contrast to a fixed, hierarchical model, where once a leader, always and at all times the leader (Clark 2012; Gabel 2012). Part of this notion of leadership is the ability to take any position in the health-care team according to the current task,

and thus to lead from behind. I will return to the idea of emergence in the critique section of this article, but it is important at this point to note that emergence is also a good illustration of the overlap between some of the leadership models, as both transformational and complexity models are said to demonstrate this feature (Avolio, Walumbwa, and Weber 2009). Like so many sociological endeavors, developing a taxonomy of leadership is far from being a matter of carving nature at its joints.

A crucial claim in relation to the transformational theories of leadership is that, unlike trait or "Great Man" notions, and partly because they are not of this type, leadership is something that can be learned: rather than an inborn trait (however deeply in the psyche that trait may dwell), it is a kind of competency (Jago 1982). This is clearly a presupposition of the numerous corporate and medical and health-care leadership development courses (McKimm and Swanwick 2011). Indeed, just as the newly discovered need for medical leadership often goes without saying, many articles describing such courses do not bother to justify the claim that leadership can be learned (Crites, Ebert, and Schuster 2008; Goldstein et al. 2009; O'Connell and Pascoe 2004; Varkey et al. 2009). This notion of competency is also consistent with the concept of transformational leadership, with its contingent, flexible, and situational identification of appropriate leaders for different settings. Furthermore, it is consistent with the idea that all future physicians should be trained in leadership, an increasingly common proposition of the medical leadership literature.

While much of the medical leadership theory, literature, and practice has concentrated on managing and improving increasingly complex systems of care, notions of leadership have also been applied to the traditional physician-patient relationship. It is suggested that individual clinicians now may demonstrate leadership within the spheres of patient-centered care and collaborative decision-making. For example, Schei and Cassell (2012) define clinical leadership as "the ability to accept, appreciate, and channel doctors' professional power into support for patient's autonomous functioning and adaptation to loss" (p. 53).

In summary, medicine and health care are utilizing theories and models that originated in the corporate sector and its academic counterparts to stimulate an appreciation of the need to apply leadership and leadership education in both increasingly complex health-care systems and the traditional physician-patient relationship. There is a normative element to the more influential leadership models, such as the transformational model, that sees leadership as contingent, situational, and consistent with explicit organizational goals and values, but also importantly as comprising a set of competencies that can be learned.

EDUCATING FOR LEADERSHIP

The Australian Medical Council (2012) recently released its revised "Accreditation Standards for Primary Medical Education Providers and their Program of Study and Graduate Outcome Statements." The outcome statements are organized under four domains: Science and Scholarship, the medical graduate as scientist and scholar; Clinical Practice, the medical graduate as practitioner; Health and Society, the medical graduate as a health advocate; and Professionalism and Leadership, the medical graduate as a professional and leader. These domains clearly envision Australian medical graduates as much more than neophyte clinicians. They imply that in addition to attaining the basic knowledge, skills, attitudes, and behaviors essential to the development of their clinical expertise, all graduates will be proto-scientists, advocates, and leaders. The individual outcome statements under Professionalism and Leadership include familiar items like commitment to high clinical standards and various ethical values, understanding of legal responsibilities of doctors, awareness of factors affecting doctors' health and welfare, and so on. However, in terms of the leadership function, the relevant outcome statement is a rather perfunctory: "Describe the principles and practice of professionalism and leadership in health care."

The revised standards and statements reflect a catch-up alignment by the Australian and New Zealand medical education accreditor with international developments in the United Kingdom, the United States, and Canada, although the statements in the corresponding documents are also low-key. For example, the United Kingdom's General Medical Council (2009) states in "Tomorrow's Doctors" that medical graduates should "Demonstrate ability to build team capacity and positive working relationships and undertake various team roles including leadership and the ability to accept leadership by others." North American medical education accreditation through the Liaison Committee on Medical Education recognizes a range of formal definitions of the knowledge, skills, behaviors, and attitudinal attributes appropriate for a physician, including those from the AAMC's Medical School Objectives Project, the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and the physician roles summarized in the CanMEDS 2005 report of the Royal College of Physicians and Surgeons of Canada (Liaison Committee on Medical Education 2012). However, there is little explicit mention of leadership. The exceptions are in the CanMEDS report, where the competency "Where appropriate, demonstrate leadership in a healthcare team" appears under the "Collaborator" category for physicians, and the competency "Serve in administration and leadership roles, as appropriate" appears under the "Manager" category (Royal College of Physicians and Surgeons of Canada 2005).

Various modes of educational implementation have been employed. Some of these are external or joint programs, where existing degree programs such as

MBAs are provided by medical education providers at the undergraduate level, or where postgraduates independently or under the auspices and sometimes financial support of health-care employers undertake such programs (Larson, Chandler, and Forman 2003). Projects at the undergraduate level are said to model leadership and teamwork, especially in the context of current methods of small-group teaching (Chen et. al. 2009). Elective and selective courses, some of which involve community projects, have also been utilized (Goldstein et al. 2009). As with other educational developments, some of these operate as pilot projects for the later exposure of all students to leadership development. For example, the UME-21 project has collated a number of U.S. medical school initiatives in leadership education that vary in their attention to management and leadership concepts and activities, and include modeling of these in clinical rotations, workshops, and other didactic sessions (O'Connell and Pascoe 2004). A whole-program curriculum in medical leadership has been developed at the Boonshoft School of Medicine in Ohio (Crites, Ebert and Schuster 2008). At my own Australian medical school, a Medical Leadership program for students that now attracts junior doctors and other participants commenced in 2010, featuring theoretical sessions, seminars with recognized leaders, and projects, leading to a Graduate Certificate in Executive Leadership (Knowles et. al. 2012; University of Queensland 2012).

Swanwick and McKimm (2012) summarize what has so far been attempted as including various theoretical strategies, such as lectures, seminars, and case studies; work-based assignments; coaching and mentoring; and reflective writing. They also emphasize the importance of linking these more traditional "educational" activities with the development of changes in the organization (medical school or health-care organization) as a whole. However, what is not yet clear is the consistency and coordination of leadership development offerings, or the appropriate stage at which to commence educational efforts and how to stage different approaches and depths of learning (Stoller 2009).

Medicine is traditionally a slow adopter of novel ideas, but it is now responding to perceptions that, if the challenges to health-care delivery are to be managed effectively, if leadership is required at all levels of medical and health care, and if leadership can be taught and learned, then development and education should be introduced promptly and at all levels of the educational continuum (Gabel 2012). Not surprisingly, there is so far little evidence of a consistent, systematic, and coordinated approach in either the undergraduate or postgraduate arenas; rather, there have been mainly local, ad hoc responses to perceived needs. One exception to the lack of systemic developments is the United Kingdom's medical leadership competency framework (NHS Leadership Academy 2012). There has also been some incipient activity in New Zealand, based on the U.K. model.

The NHS Leadership Framework purports to provide a consistent approach to leadership development for all NHS staff, irrespective of discipline or role,

and explicitly states that leadership is not restricted to those holding designated leadership roles, since leadership can come from anyone in the organization (NHS Leadership Academy 2011). The framework covers various domains such as Personal Qualities, Working with Others, Managing Services, Creating the Vision, and so on, with sub-elements and descriptors within each domain, in addition to indicators of behaviors at different leadership "stages," such as teams, services, wider organizations, and the whole organization.

In New Zealand, a Ministerial Task Group on Clinical Leadership published *In Good Hands* (2009), which has framed developments in leadership and clinical governance since then. This report appears to have spawned some local and regional initiatives, but there is as yet no national clinical leadership development program.[1]

CRITIQUE

Questions concerning the coordination of leadership education, and concerning pedagogical approaches, depth, and staging, together with the absence of widespread national initiatives, presuppose the fundamental ideas that medical leadership is somehow lacking, and that consequently a significant new educational effort is required to correct the shortfall. It is to these fundamental but largely unquestioned assumptions that the following section of this article is addressed.

Asking the Right Questions

A number of questions have focused the minds of academics, clinicians, and others in the literature of medical leadership and its development. These include: what is/are the best model(s) for medical leadership? how can we apply leadership theories to health care management/delivery and the clinical relationship? and what are the best ways to educate medical students and postgraduates for the new leadership roles they will fill?

The questions that do *not* appear to have been asked and responded to, so far in the literature on medical leadership, include the following: what is the philosophical/phenomenological/ontological/empirical status of leadership? if there have always been medical leaders, why do we now see such a focus on medical leadership, and why do students and junior doctors now need to be *trained* to be leaders? what does the assertion that *all* students/doctors should be trained to be leaders imply for the nature of the leadership that they will display, vis-à-vis that of medical leaders of the past? are the things that are advocated under the call for medical leadership development and education always examples of leadership, or are they sometimes other things that have simply been relabeled? are there any aspects of leadership per se that can be taught and learned, or are the

[1]K. McHardy, Fellow in Health Leadership and Innovation, Ko Awatea and Health Workforce New Zealand, personal communication, May 14, 2013.

kinds of things that can be taught and learned specific competencies that someone who is a proto-leader or indeed a well-recognized leader can usefully add to his or her skills? what alternative explanations might be given for the current phenomenon of medical leadership and the apparent urgency concerning its development, in the light of the questions above?

Leadership and Complexity

What health care crisis? Questions about incomplete insurance coverage, inequitable access to health care, and social inequities in health status are not new. Even the demands for high-cost treatments and the pressure that ageing populations will impose on health care do not amount to a crisis. Crisis language often serves political purposes: for example, political parties often invoke it in relation to different categories of crime, in order to attract the law-and-order vote. As with a number of words and concepts, we should use *crisis* carefully in relation to health care, lest we cheapen its meaning. Few people would disagree that the bombing of Pearl Harbor precipitated a genuine political and military crisis, or that the Great Depression constituted a social crisis, or that the wars in Somalia and Syria have spawned humanitarian crises. Perhaps there would be consensus that in numerous developing countries there is also a crisis in health care. But in the West, the use of the term in relation to health care is severely strained.

Complexity is historically relative. Each civilization is more complex than its predecessors, but the conceptual and technological tools for managing each one are not restricted to those that were previously available. As leadership is part of that management process, and it can call on the tools available, it cannot be the case that greater complexity requires "greater" leadership. The need for management of complex systems and the need for leadership are sometimes conflated. Complex systems clearly need intelligent managers who can plan, budget, appoint, measure, and so on, but leadership is different from management, and it has not changed (Kotter 2013; Swanwick and McKimm 2011).

Conceptual Concerns

As suggested previously, once something has been reduced via description, analysis, and categorization, it is often tempting to consider that it can be taught. For example, some have suggested that because we think we understand something of what "clinical wisdom" or "clinical intuition" consists of—including scripts, schemas, pattern recognition, tacit knowledge, and so on—we can and should begin to teach students how to acquire these strategies at earlier stages of training (Mandin et. al. 1997; Truman 2003). However, if these elements constitute something that necessarily arises from experience, the idea of somehow imparting it through formal teaching at early stages makes no sense (Moulton et al. 2007; Schuwirth 2002).

The same "teachability temptation" arises in response to the analysis and

typology of leadership: if we can descry leadership's elements and kinds, we think we can reassemble it within the student. The problem with leadership is not so much that, like clinical intuition, it requires time, experience, and practice to mature, but that it is a contextually emergent phenomenon. With sufficient time and experience, most neophyte clinicians will develop at least an adequate ability to recognize patterns, to make what appear to be automatic clinical assessments, and to make judgments under uncertainty. But not everyone emerges as a leader, and many leaders only emerge under the appropriate conditions. (While the transformational model of leadership is based to some extent on a contextual necessity for leadership's existence, such that different people may emerge as leaders for different purposes, this is not the same as claiming that the model can be taught. In fact, the transformational model's supporters, for the reasons I am giving, should argue that if their model is correct, it *follows* that leadership cannot be taught).

J. M. Barrie's masterful 1902 play *The Admirable Crichton* illustrates this emergence. Crichton, butler to the aristocratic Loam household, accepts without question British social stratification and his role in it, but when the family and staff are shipwrecked on a far-flung island, he gradually takes over as leader in the new circumstances, where only he has the resourcefulness and practical acumen to ensure their survival. On being rescued, the original positions of lord and butler are resumed, with only Crichton being completely at ease with restoration of the initial relativities. While the play is seen as a light-hearted dig at the English class system, it also illustrates the unpredictable and contextual nature of genuine leadership, such that the idea of training for leadership becomes not merely superfluous, but odd.

As Steven Spielberg commented in a recent interview about the making of his film *Lincoln*: "I just think that the qualities of leadership are unknown even to the leader until he's tested and given a challenge. . . . But you never really know how good of a leader you are until there is something there is [*sic*] lead us to, toward or through or to overcome" (Australian Broadcasting Corporation 2013).

If this observation is correct, teaching leadership would amount to consciously attempting to instill, or at least facilitate the development of, something that is already but inchoately "there" in an unknown number of people—despite the fact that even if whatever it is that blossoms into leadership is "there," it will not necessarily emerge. To imagine that this can be done generally seems to be an exercise in hubris, and it also raises the question as to how leaders in the Crichton–Spielberg sense will rank against those who become "leaders" via formal training and certification. The claim that everyone can be educated to be a leader also clearly dilutes the very concept of leadership: it is the reductio ad absurdum of the educational competency model. Furthermore, the teachability thesis sometimes trades on the fallacious idea that, because it is a mistake to assume that excellent clinicians will make good medical leaders in

virtue of their clinical acumen, it follows that medical leaders therefore need to be formally educated or developed.

Education for Leadership

Thus far, educational endeavors in medical leadership reflect the fact that a number of the questions listed above have not been asked. The perfunctory nature of the statements of educational accreditors and framework producers suggests that leadership education is more a fad or fashion than a well-thought-through educational project. This is borne out in some of the selective (non-general) training programs, where the only apparent selection criteria appear to be the demonstration of proto-leadership behaviors and achievements (Knowles et al. 2012). In such cases, those who are already *emergent* leaders are admitted to programs that will teach them about the different academic models of leadership, in order to produce *certified* medical leaders of the future.

While academic medical education has developed a strong presence over recent years, with academic departments and units, strong individual and collaborative research, and an increasing literature, there has been little empirical research directed towards answering some of the questions raised above (Strauss, Soobiah, and Levinson 2013). For example, how do training courses measure leadership, in order to know that they have been successful? What studies are being conducted, involving leadership trainees and other students as controls? What empirical research is being undertaken to compare leaders who have and have not been formally trained? What are the attitudes of students, teachers, clinicians, managers, and leaders to the proposals to generalize leadership training? The dearth of apparent research into such questions may reflect the early stage of this particular educational development, but it may also indicate that in the area of leadership, it will prove impossible to answer many of them.

National Initiatives

The United Kingdom and New Zealand offer a more systematic and coordinated approach to leadership education in the postgraduate arena, although there is no evidence as yet of any national plans or outputs in New Zealand. The 2009 report *In Good Hands* is strongly modeled on the NHS Leadership Framework, so the following comments refer to the U.K. document. As stated above, the framework does not restrict leadership aspirations or qualities to those holding designated leadership roles, and it includes a number of domains, sub-elements, descriptors, and indicators of behaviors relevant to different stages and roles.

The *Summary* document for the Leadership Framework devotes 14 densely typed pages to those various categories and sub-categories, making any healthcare workers' coming to grips with their putative obligations a significant burden in itself. But more importantly, it marks off two domains (Creating the Vision and Delivering the Strategy) as focusing more on the roles of individual leaders and particularly those in senior positional roles. Furthermore, the major-

ity of domains, elements, descriptors, and behavioral indicators consist of capacities, qualities, and competencies that we would certainly expect to see in all good leaders, but that are by no means restricted to leaders. The notion of leadership contained in the framework is hence both ambiguous and drained of much of its meaning. While it is true that leadership can come from anyone in the organization—in the unpredictable, emergent sense—it is not true that everyone in the organization will exhibit leadership qualities and become a leader, whether or not they participate in the activities of the framework. The concept of leadership has been expanded far beyond its legitimate boundaries. The same process can be seen at work in considerations of the clinical encounter.

Leadership in the Clinical Encounter

Among the significant changes in medicine and health care are the developments in patient-centered care and its elemental collaborative decision-making between physicians, other health professionals, and patients. These developments have been stimulated and accompanied by the loss of unearned, authority-based trust in the medical profession, largely as a result of exposure, analysis, and institutionalization via the civil rights and bioethics movements, and accompanying biolaw (Van der Burg 1997). It is interesting to now witness the attempted usurpation of these changes by the leadership movement. As indicated above, for example, Schei and Cassell (2012) have introduced a notion of clinical leadership as the ability to utilize doctors' professional power to support patient autonomy and patients' ability to adapt to loss.

Another author suggests that the ability to advocate for the patient, to respond appropriately to a patient's refusal of treatment, and to recognize one's own limits should be included in the qualities exhibited by medical leaders (Gridley 2012). But these worthy abilities and actions are just the things that medical training has more recently set out to achieve in response to the critiques of medical practice over recent decades within the disciplines of sociology, theology, bioethics, and law. These abilities and actions now appear to have been annexed and rebranded as elements of leadership. Of course, once this occurs, it is then easy to proclaim, as a number of authors are doing, the importance of educating *all* potential doctors to be leaders.

One of the reasons for the mistake of believing that doctors must now be leaders, even in the clinical consultation, is that leadership is complexly tied up with the exercise of power, so it seems that the doctor-patient relationship, like others, should be a kind of leader-led relationship. Gabel (2012) defines leadership as "working in socially appropriate ways to influence others in subordinate or follower positions to achieve principle-driven goals and objectives that these individuals may not have wanted to reach, may not have thought of reaching, or may not have had the courage or motivation to attempt of their own," and sees power as involving "the strategies used by leaders to influence those in subordinate or follower positions to achieve these important goals" (p. 1153). Since

influence is necessary to any conception of leadership, leaders influence their followers and subordinates, and doctors have certain powers in relation to patients, it might appear to follow that doctors are leaders of their patients.

Gabel illustrates this idea with a clinical vignette in which a hurried doctor prescribes anti-hypertensive drugs for a patient, warns of a couple of side effects, and asks if the patient has any questions. The patient says no, perceiving that the doctor is in a rush, but she feels anxious and vulnerable. She does not keep the one-month follow-up appointment, due to having found the doctor curt and also having not contacted the doctor after a rash appeared and discontinuing the medication. Gabel analyzes the situation as one of the exercise by the doctor of her "expert" power (diagnosis and prescription), but failure to exercise "referent" power, or the power to motivate others through doctor-patient identification of goals and values and via interpersonal skills. Gabel's take on what happened in this consultation is that the doctor should have created "an image or goals with which the patient could identify," spent more time with the patient, emphasized the importance of treatment to her health, inspired/motivated her to be compliant, and asked about related concerns with diet and lifestyle (p. 1156).

Gabel says that all these strategies "are signs of transformational leadership" (p. 1157). But given that the strategies are all described without the need for leadership language, that they all integrate good clinical management with collaborative decision-making, and that this sort of integrated collaborative approach predates the emergence of the fashion for medical leadership, one can be forgiven for thinking that promoters of medical leadership like Gabel have got the cart before the horse. Many doctors have already adopted certain consultation styles and processes in response to the critiques of the more paternalistic models of care of yesteryear, but we are now told that these styles and processes are features of something new called (transformational) leadership that now should be applied to clinical practice. It is not that doctors do not wield power—of course they do, and like other professionals and many others besides, they must. The exercise of power is ubiquitous, but it is not restricted to leaders. Therefore, power and leadership should be uncoupled, in order that the doctor-patient relationship is not mistakenly seen as an example of a leader-led relationship. Contra Schei and Cassell (2012), clinical leadership is not the ability to utilize doctors' professional power to support patient autonomy and patients' ability to adapt to loss. This ability existed prior to any talk of medical leadership, and such "clinical leadership" simply amounts to the exercise of clinical moral responsibility, something that leaders and non-leaders alike should exercise. Similarly, contra Stoller (2009), "congruence with a healing mission" does *not* require "that physician-leaders possess and model the traits of compassion and hopefulness" (p. 877), because we have surely always wanted physicians qua physicians to possess and model these traits.

Leadership: Emergent, Unpredictable, Unconscious

Taken together, a number of the factors I have discussed point to the idea that medical leadership and training for medical leadership have been seriously misconceived. Medical leadership is nothing new; concepts and practices that are now placed under the rubric of leadership predate leadership research and its literature; and the exercise of power in the organizational arms of medicine and in the clinical encounter is not only the preserve of those who should reasonably be considered to be leaders. Furthermore, medical leadership appears to have attracted little by way of empirical research to test hypotheses of interest. The "teachability temptation" is understandable but highly problematic, and the selection criteria for some of the training that does occur presuppose the "protopresence" of what is to be taught.

How are these observations to be explained? Many of the clues lie at the surface of the leadership literature itself. The more recent models, such as transformational and complex adaptive leadership, insist on a clearly moral quality to leadership, including ideas such as the facilitation by leaders of followers' potential, consistent with organizational goals and values; leading from behind in health-care teams; and eschewing fixed leadership hierarchies. In addition to these moral qualities are those that point to the difficulty of pinning down leadership in anything approaching a scientific fashion. Both the transformational and the complexity models emphasize the emergence of leadership at different levels in different contexts, and in particular the complexity model describes leadership as "an interactive system of dynamic, unpredictable agents that interact with each other in complex feedback networks, which can then produce adaptive outcomes such as knowledge dissemination, learning, innovation, and further adaptation to change" (Avolio, Walumbwa, and Weber 2009, p. 430). On this model, "leadership is an *emergent* phenomenon within complex systems" (Hazy, Goldstein, and Lichtenstein 2007, p. 2).

The interesting irony here is that, having attempted to delineate leadership in scientific ways over the past three decades or so, we have arrived at a point where science drops out of the picture. The unpredictability that characterizes the most popular leadership models reflect Spielberg's observation that the qualities of leadership are unknown even to the leader. No one, including Crichton himself, could have predicted what happened on the island, prior to the natural unfolding in those circumstances of his leadership of the group. Similarly, Chater's community leadership emerged in response to the flooding of his town. While we might have some expectations of certain individuals in light of their expertise, this is not the same as predicting that a particular expert will also emerge as a leader. If genuine leadership is unpredictable, a science of leadership appears to be out of the question. And if this is the case, the thesis that leadership consists of some collection of competencies that can be taught and learned also evaporates.

Against this conclusion, it might be claimed that the idea that leadership is emergent is nothing more than a way of evading the work of discovering what it really is, and how people who do emerge as leaders are formed. If the formation processes can be uncovered, it might be possible to foster the leadership qualities and abilities that are called for in the face of genuine crises, even if this is not achieved through formal teaching arrangements. Are the formation processes partly genetically determined, for example? This is possible in principle, of course, but if there are genetic sources of leadership qualities, then fostering those qualities seems otiose. Moreover, the apparently emergent nature of leadership suggests that it is something that supervenes on those qualities—many people may well display many of the qualities that are considered to be elements of leadership, but still not emerge as leaders.

On the other hand, the formation processes may be partly, or largely, experiential. Did Lincoln's formative years help prepare him for eventual presidential office? Since many people who do not become leaders share the kinds of experiences that leaders have had, the prospect of conducting research into what experiences prepare the ground for leadership seems unlikely to be fruitful.

MOTIVATIONS

In the modern era, the medical profession has contracted with society to provide medical care to patients and populations at high standards and in a trustworthy way, and in return has been vouchsafed generally high social status and remuneration, irrespective of the variations between Western countries in terms of the public/private mix of service delivery. However, the profession has been perceived by the community to have reneged on the contract in various ways over the past 50 or more years, and in response, the profession's social, political, and economic powers have been curtailed in many ways. The profession has also seen its autonomy eroded significantly by the advent of a managerial culture within health-care delivery and education, with the loss of traditional controls long enjoyed by clinicians and clinician educators. Furthermore, it has been criticized for deficiencies from within its own ranks and from beyond the profession.

It is possible that the calls for leadership and leadership training represent a response to the multi-barreled critiques leveled at the profession for perceived failures, and to the perception that medicine has been too reactionary and self-serving. The current, more explicit calls for leadership and leadership training may reflect the profession's need to convince the community that it continues to deserve its long-held social position and to "continue to be invited to take the reins of clinical services" (Swanwick and McKimm 2012, p. 93).

Likewise, the insistence on insinuating the language of leadership into the clinical relationship can be read as an attempt to maintain a position of power vis-à-vis the patient, a characteristic of the profession that has been significantly eroded over recent decades. Providing "leadership" in the clinical relationship

does not sound like the naked paternalism of yesteryear, especially if it is said to be supporting patient autonomy (Schei and Cassell 2012), but lobbing leadership rhetoric into the clinical consultation keeps the leader-led dream alive, under cover of the medical versions of terms such as sharing, communication, leading from behind, goals, values, responsibility, vision, collaboration and so on.

CONCLUSION

Medical leadership and leadership training are relatively recent developments that have received little if any theoretical analysis. Like other phenomena, they appear to have been more or less adopted from the corporate world, along with academic underpinnings that themselves have followed an interesting trajectory. The leadership literature has provided an essentially descriptive-historical account of leadership models, but at the same time it has encouraged models of leadership that feature facilitation of the participation of all in developing and realizing institutional goals and values, and the democratization and distribution of leadership in contrast to traditional hierarchical models. Most recently it appears to have been "discovered" that leadership is a phenomenon that emerges from complex relationships and interactions, is highly contextual, and is hence unpredictable. We appear, to paraphrase T. S. Eliot's famous expression, to have not ceased from exploration, but at the end of all our exploring arrived where we started and to know the place for the first time (Eliot 1942). But others, like Barrie, did know this place extremely well. Leadership as emergent is not a new discovery.

This emergence and unpredictability of leadership, and hence its immunity from clear scientific manipulation, has crucial implications for all walks of life including medicine. Something that is emergent and unpredictable is not reducible, and hence not teachable as a kind of competency. I have given some incipient indications why this is so, and pointed to some contradictions in relation to the "teachability temptation" that deserve further scrutiny, including the conceptually bizarre idea that leadership instruction should be provided for all. Leadership is also an inappropriate concept for understanding the doctor-patient relationship, either in a descriptive or a normative sense. Finally, I have provided some somewhat speculative, though not altogether unfounded reasons why we have witnessed the development of these phenomena in recent times, to the effect that they represent a reaction to the erosion of medical roles and status. I hope the paper will stimulate further analyses of medical leadership and leadership education.

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